Please complete and return to: **Insure Montana**
840 Helena Avenue
Helena, MT 59601

Fax: 406-444-3497

INSURE MONTANA

EMPLOYEE PREMIUM ASSISTANCE APPLICATION

COMPLETE THE FOLLOWING INFORMATION FOR THE EMPLOYEE:

DEMOGRAPHIC INFORMATION

Employee First Name	Last Name		Employer/Business Name
Address	City	State	Zip Code
Mailing Address if Different	City	State	Zip Code
Telephone - Home / Telephone – Work	Telephone – Other	**Email Address*** (please print clearly)	

***Please indicate if you want to receive an Electronic Fund Transfer receipt by E-mail to the address listed above.** **□YES □NO**

LIST ALL HOUSEHOLD MEMBERS THAT RESIDE IN THE HOME MORE THAN 50% OF THE YEAR INCLUDING DEPENDENTS ATTENDING COLLEGE (ATTACH AN ADDITIONAL PAGE IF NECESSARY)**:**

HOUSEHOLD MEMBERS

Name (first, middle initial, last)	Relationship to Employee	Include in Insure MT Yes or No; OR, List name of insurance company if other than Insure MT BCBS.	Social Security Number	Date of Birth	Fulltime College Student (Yes or No)
	Employee				

LIST HOUSEHOLD ANNUAL GROSS (BEFORE TAXES) INCOME FROM ALL SOURCES, INCLUDING: WAGES, SOCIAL SECURITY OR DISABILITY BENEFITS, CHILD SUPPORT, WORKER'S COMP, UNEMPLOYMENT COMP, ETC.

HOUSEHOLD INCOME

Please check the box that represents your total household annual gross income:

Single:	Married (no children):	Single with children:	Family (married with children):
_____ less than $9,570	_____ less than $12,830	____ less than $16,090	_____less than $19,350
_____ $9570- $14,355	_____ $12,830- $19,245	____ $16,090- $24,135	_____$19,350- $29,025
_____ $14,355- $19,140	_____ $19,245- $25,660	____ $24,135- $32,180	_____$29,025- $38,700
_____ $19,140- $23,925	_____ $25,660- $32,075	____ $32,180- $40,225	_____$38,700- $48,375
_____ $23,925- $28,710	_____ $32,075- $38,490	____ $40,225- $48,270	_____$48,375- $58,050
_____ $28,710 and over	_____ $38,490 and over	____ $48,270 and over	_____$58,050 and over

CERTIFICATION AND SIGNATURE

I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information which may include a possible criminal offense (MCA 33-22-2009). I agree to provide documents to verify information on this application if requested. I understand that State staff may obtain documents and/or information to verify statements on this application. I also understand that I must report if my coverage ends within 30 days of the change. Any premium assistance payment I receive and am not entitled to will be required to be repaid to the Insure Montana program.

Employee Signature _____ Date _____

Bank Account Information

Information collected will be used for Electronic Funds Transfer (EFT) to deposit your monthly premium assistance amount. **Please include a voided check with this form.** If a voided check is not available, attach a letter from your financial institution indicating the bank transit routing and account numbers. The document must be on bank letterhead and signed by a bank official. **Deposit slips are not acceptable.**

Financial Institution Name: _____

Transit Routing Number (9 digits): _____

Bank Account Number (include zeros, do not include check number): _____

Name on account: _____

Type of Account (please mark **one** only): _____ Savings _____ Checking

Date Bank Account Opened: ____/____/____

Bank Address: _____

City: _____ State: _____ Zip: _____

Bank Phone Number: _____ Ext: _____

Please attach voided check in this space.